1300 Kansas Avenue, Suite B
Great Bend, Kansas 67530

HEALTH DEPARTMENT
Barton County
Barton Invests In Growth

(620) 793-1902

Pregnancy Maintenance Initiative
Client Satisfaction Survey

1. **Agency Name:** _____
2. **Agency City:** _____
3. **How did you learn about these services:**

Friend/Relative
Pregnancy Care Provider
Media (TV, radio, newspaper)
Social Media (Facebook, Twitter, etc)
Adoption Agency
Hospital
Brochure from agency listed above
Church
Health Department
Another agency: _____
School: _____
Other, specify: _____

4. **Check the services that you received as a result of your participation with the Teen Pregnancy TCM.**

Prenatal Medical Care
Medical Care (non-pregnancy related)
Client Infant
Housing/Utilities
Alternative Education
Paternal Involvement Support
Adoption Guidance
Drug/Alcohol Assessment/Treatment
Domestic Abuse Protection
Child Care
Parenting Education/Support
Transportation

5. **How long did you wait for your first visit with the Teen Pregnancy TCM case manager?**

Less than 1 week
1 week
2 weeks
3 weeks
4 weeks or more

6. **Did you have problems getting to the services (e.g., transportations, appointments conflicted with work schedule or school, child care)? No Yes Describe the problem:** _____

_____

7. **Were the days and times for services good for you? No Yes Describe the problem:** _____

_____

8. **On the average, how long did you have to wait before you were seen by the case manager or other staff at this agency:** less than 15min
15-30min.
31-45min.
46min.-1 hr.
more than 1 hr.

9. **During your Visits:**

Did the case manager carefully listen to you?	**Yes**	**No**
Did service providers carefully listen to you?	**Yes**	**No**
Do you feel you participated in the goal planning?	**Yes**	**No**
Were things explained in a way you could understand?	**Yes**	**No**

If you checked "NO" to any of the above, please explain: _____

_____

10. **Did you feel you were fully informed of:**

Available services to continue your pregnancy?	**Yes**	**No**
Location of services?	**Yes**	**No**
Requirements of services?	**Yes**	**No**
Length of services during pregnancy and after?	**Yes**	**No**

11. **If these services had been unavailable, what would you have done in relation to your pregnancy & other needs?**_____

_____

_____

12. **Would you recommend these services to a friend or relative?** **Yes** **No**
13. **How old are you?** _____**years.**
14. **What is your race?** White/Caucasian Black/African American American Indian/Alaskan Native Asian Native Hawaiian/Pacific Islander Other
15. **Do you consider yourself to be of Hispanic origin?** **Yes** **No**